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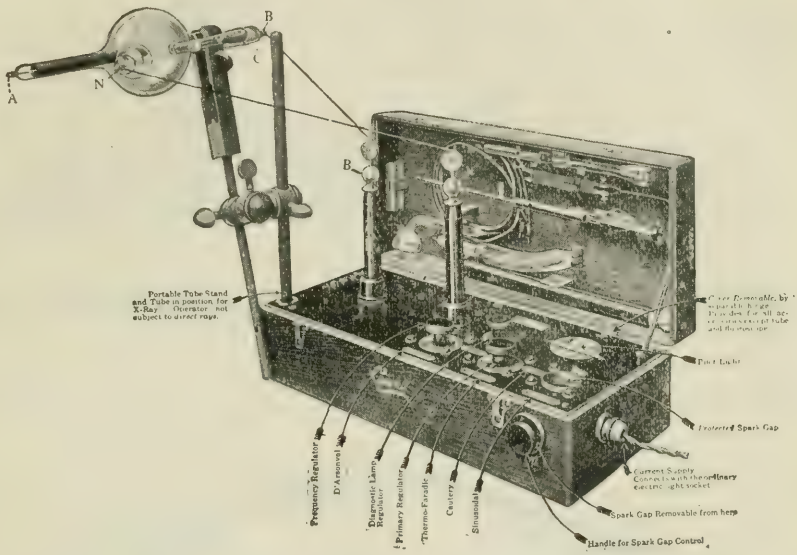

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Original Communications

ON THE RADICAL REMOVAL OF THE CONDITIONS CAUSING ARTERIAL CHANGES LEADING TO NON-PSYCHOGENIC DISTURBANCES OF THE NERVOUS SYSTEM.—CASES.*

BY TOM A. WILLIAMS, M.B., C.M., EDIN, *Washington, D. C.*

I.—The "Neurasthenia" of Sclero-genetic Toxicosis, without very light blood pressure.

II.—Diagnosis of this state by Neurological Symptoms and Signs.

III.—Cases: (1) Focal Epilepsy from Arterial Changes; (2) Incipient Presenile Melancholia; (3) Metabolic Psychasthenia.

IV.—Diet Most Important Element of Successful Treatment.

Whether persistent high blood pressure is itself the cause of arteriosclerosis or whether it is only another effect of toxicosis which degenerates the arteries is still a problem.

We now know that sclerosis of the arteries occurs in some subjects without a marked rise of blood pressure (Councilman). It is in these cases that we have to rely upon other signs for a diagnosis, more especially when nephritis has not occurred. It is in the nervous system that these reveal themselves earliest; and it is unfortunate that sclero-genetic toxic states are so often overlooked by physicians on account of the facility with which

it has been the habit to label "neurasthenia" the varying symptoms in the causation of which circumscribed lesions of the nervous system can be excluded.

It needs to be reiterated that there is no nosological entity, neurasthenia, which is only rather a loose name for a clinical condition attributable to some definite cause or causes, generally intoxicative, such as hypo or hyperthyroidism, deficiency of the adrenals, incipient Bright's disease, disturbances of the digestive organs, tuberculosis, syphilis, pellagra or other chronic infections, animal parasites, a poor, badly balanced or excessive diet, or the imbibing of exogenous toxins; and, lastly, mental worry and unhappiness, which act indirectly by perverting metabolism and thus producing the toxicosis which determines neurasthenia.

It is the doctor's business to find out the causes in each case and to remedy them. In searching for these, the general practitioner may require the aid of specialists. This is particularly so where the nervous system is affected; for I am sorry to say that neurological technic has been acquired up to the present by very few of the busy men who pursue general or special practice. In illustration of these statements, are reported the following cases, where the gravity of the symptoms led to an early consultation, which enabled proper treatment to be instituted in time, so that good health was quickly restored.

Case I.—A man of 64, chief architect in the Indian Service, consulted me February 10, 1910, having been sent by Dr. Phillip Roy because of the recent occurrence of epileptiform convulsions with loss of consciousness.

The first attack had occurred in May, 1909, at an elevation of twelve thousand feet, near Durango, while he was inspecting the school buildings there. He was unconscious for half an hour. The second attack occurred shortly after, upon leaving the train in Chicago, while making for the staircase. It lasted about an hour. A third attack took place that July in his office, lasting one and a half hours. The fourth and last had occurred two nights before his visit to me, while he was visiting a friend and sitting down. It lasted three hours.

The attacks are preceded by a creeping sensation in the left upper arm, passing slowly down to the hand, which becomes numb. In about fifteen minutes, unconsciousness supervenes. The face is said to be flushed; that he is uncertain whether there are convulsions, though others have told him that there are. The duration of the attacks was only surmised.

Previous History.—Had scarlet fever at six without bad sequelae. An active, healthy man, except for two years of asthma twenty-five years before, a result of constant attacks of catarrh. It was cured by working as a farm-hand for three weeks. He smokes two cigars and a pipe a day. He took coffee and was a heavy drinker until after the attack; now he has ceased to even take tea. He has always been abstemious in eating; but has been fond of salty foods. He drank "when he felt like it." Since these attacks, he has had a pain over the forehead when coryza occurred. As he had read that insanity might come on from this catarrh, he was at first a little anxious about his state, but soon steeled himself against it.

The pain in the head was rather a feeling of depression and a grumbling pain like that of catarrh. The discharge was slight, and the headache disappeared when the attack ceased. He used to sleep quite well, but about the time of his attacks, he began waking in the early morning, and could not fall asleep again. This persisted.

He had been recommended to eat more, and to take fat meat, and this he had done.

Physical Examination.—Reflexes: Knee kick, right greater than left; Achilles reflex, right less than left; triceps, left greater than right.

Radials equal. None markedly exaggerated. Plantar reflex is normal. The left cremaster is absent.

Sensibility.—No abnormality in lower limbs to pain, touch, temperature, nor attitudes, though the latter are sometimes wrongly named, but correctly recognized.

Arms.—Perfect localization of light touches, both segmentally and axially. Spacing sense of fingers normal. Other modalities

normal except sense of attitudes poor, especially in the left hand. No hemiopia or colour inversion of visual fields.

Motility.—Normal, but left fingers weaker than right. Diodocokinesis regular. Pupils contract promptly.

Psychic Functions.—He thinks his memory is weakened since the attacks. There are no disorders of speech. Emotionally he has always been easily excited when there was a cause, and has been accustotmed to occasional sadness.

Diagnosis.—The localization of the aura in the left arm and hand, along with the increase of the triceps reflex and the loss of the cremasteric, point to an organic perturbation of the sensori motor area of the right hemisphere, probably mainly in or near the cortex of the central fissure, opposite the second frontal convolution. The cremaster-governing fibers are, of course, attacked in some other situation.

As neoplasm and granuloma were each unlikely, and as the man's age is that of arteriosclerosis, of the state preceding which the recently acquired matutinal insomnia was indicative, I believed it wise, although lacking proof, to adopt the supposition of sclerogenetic toxicosis, and to put it to the experimental proof of therapeutics.

Accordingly, a diet light in proteins was ordered, and coffee and tobacco were forbidden. The result was confirmation, as the patient, one year from the consultation, remains free from attacks and insomnia, and is perfectly well able to perform his very strenuous work, often in high altitudes.

I believe that the first attack was inaugurated in consequence of an ischæmia of a part of the right Rolandic region, due to the heart, strained by the high altitude, not being able to keep full of blood a partially sclerosed vessel distributed to that area. The second attack was likewise due to a sudden demand upon the heart upon leaving the train after a very hot journey.

Case 2.—Physician aged 68, referred to me by Dr. Balloch because of a "nervous breakdown." For over a year, he had been worrying over the death of his son and the serious illness of his wife and daughter. He was suffering from severe in-

somnia, tinnitus aurium, and numbness and tingling in the toes of the left foot and in the hand; sometimes less markedly in the right. He sometimes lost the ability to distinguish one from two pins between thumb and fingers. His power of endurance and sight and hearing had markedly diminished, and his former optimism had changed into an incapacity for enjoyment. All the organs were normal,, but he had lost about twelve pounds, although the appetite was fairly good. He believed that he was not physically ill.

On questioning it was found that he had slept badly for about five years, waking in the early morning, unless he took diethylmalonylurea, of which he used five grains every fourth night. On waking, sad thoughts of his son's death and daughter's troubles made him weep.

Physical Examination.—Reflexes rather active. Motor functions and diodocokinesis well performed. Sensibility normal. Heart normal. Pulse slow and regular. Blood-pressure 187 mm. Hg. Liver rather small. The paresthesiæ disappear when the parts are stretched, and occur only when he worries.

Diagnosis.—Sclerogenetic toxicosis was diagnosed from the raised pressure, the nature of the insomnia, the paresthesia without sensory defect, and the loss of endurance.

Treatment.—A low purin and protein diet was prescribed, and hypnotics were forbidden. In a few days he began to feel better, and now, nearly two years later, he remains quite well. He had been taking a popular aromatic caffeine beverage, and this was stopped as soon as I learned of it.

It is not only in the aged that the presclerotic syndrome with nervous disturbances occurs and can be removed by means of a diet low in nitrogen in purin.

Case 3.—Metabolic Psychasthenia. An engineer of 38, referred by Dr. Atkinson, powerful, energetic man, formerly accustomed to active work, began to be unable to concentrate upon the office work, to which he had confined himself for over three months. Previous to this, he had been much less active; and latterly, he had been very much worried by an official inquiry

into a contract for which he had been mainly responsible. For no cause known to him, he feels a dread in the mornings, and an indecision in business matters is now realized to have been present several months. There was no syphilis nor any other organic disease.

He had been improved by three weeks in the woods, during which he was very somnolent, but relapsed at once upon return, and could hardly stand his morning suffering. There was no insomnia.

Physical Examination.—The reflexes were rather active; but there was no objective change in the lower neurones; there was no amnesia; the sexual hygiene was normal. He was much depressed, and longed to go away from it all for a year, which he could well afford to do.

Treatment.—He was sent for three weeks into the mountains. This time he fully recovered on account of the light diet which he took. Breakfast and supper were fruit and milk, and his mid-day dinner was vegetables and six ounces of meat; after a few days, cereals were added morning and night.

As prevention excels cure, such results are better than that obtained by removal of effects by baths, electricity or chemical eliminants (diuretics, sudorifics, purgatives), or antagonists (iodides, nitrates), or still worse, narcotics, hypnotics or calmatives, which only mask the disease while it progresses.

THE DIET IN ARTERIO-SCLEROSIS AND NEURASTHENIA OF THE CLIMACTERIC.

To prevent the formation of toxins is both easier and more effective than to eliminate them when formed; although, of course, this can be done by stimulating the emunctories of the skin by baths, of the bowels by purgatives, or of the kidneys by diuretics, or of the lungs by active exercise, or of the whole organism by electricity. The supposition of the effects of toxins by counteracting substances, such as the nitrites or iodides is still less desirable; and no condemation is too great for the masking of the warning symptoms by means of sedatives, such

as bromides or hypnotics, and narcotics, such as chloral, morphine, alcohol or the synthetic drugs.

Another measure to be reprehended is the whipping up of the body reactions by means of the strychnine or caffeine groups of alkaloids.

As the patient's ill health is due to his inability to metabolize the excess of protein which he had formerly taken with relative impunity, the indication is to see that he takes only the physiological amount, which for a person past midlife should not exceed fifty grams per day. At the same time, calorics must not be deficient. In the third place, the vegetable salts must be supplied in sufficient amount for free secretory and excretory activity.

I give a sketch of a diet, which of course must be varied to individual cases.

While dressing, five to ten ounces of hot water containing ten to twenty grains of either sodium sulphate, potassium citrate, sodium phosphate or similar alkaline saline, according to the nature of the case. Half an hour later breakfast of a *large* plate of fruit and milk or cream, followed by abundant cereal and milk, with bread and butter. No meat, eggs or fish. Wait five hours. Dinner. Not more than four ounces of meat or fish, which must be quite fresh, a *very large* plate of green vegetables; potatoes sparingly, and preferably nothing more than perhaps a taste of sweets. The evening meal, five hours later, may be a repetition of the breakfast; but for it succulent vegetables may replace the fruit, and macaroni or a similar dish may be substituted for the cereal. Thirst and hunger between whiles may be satisfid by water and fruit about one hour before a meal or during the night. The purins are avoided; so that meat juices are abstained from; and soup, which may be taken at dinner or supper, must be made entirely of vegetable food. Alcohol is forbidden, even as beer or wine. Tea, coffee, cocoa and kola must be abstained from; as, besides being closely allied to the xanthins bodies, they are toxic to the nervous and circulatory systems.

Gradually this diet is added to, an occasional egg being given at breakfast or supper; and the patient very soon learns what suits him best. Some culinary ingenuity is needed to give variety to a diet which at first appears monotonous. In this respect, the tastiness of well prepared whole wheat bread is a great gain.

Gentle and regular *exercise* twice daily is a great aid to healthy metabolism; and proper calmative *baths* are most beneficial. Of course, proper *psychotherapy* to ally the patient's alarm is of great importance; besides which it teaches him the real status of his health, and provides him with the means of counteracting his mental depression by the knowledge that it has a physical source, and will pass away as this improves. Sometimes, the morbid depressive ideas are somewhat fixed; and they must then be met by frequent rational persuasion to readjust the patient's point of view. The effect of a change of environment is often only temporary, unless it is not made merely empirically. If it is made part of a psychological reconstruction and guided by the physician, it should, however, help rather than hinder the resumption of work, even in an unsatisfactory environment.

1758 K Street.

TWO STANDARD, OFFICIAL THERAPEUTIC REMEDIES.

N. A. R. D. Notes.

The following two official preparations have much to recommend them. They are here commented upon at this time because they are seasonable and because they are worthy the confidence of every physician. They are meritorious products and as made by the capable pharmacist, have a maximum of therapeutic efficiency.

TINCTURA VIBURNI OPULI COMPOSITA, N. F.

The Compound Tincture of Viburnum represents in each 4 Cc. (1 fluidram) dose, the following: 2 grains each of Viburnum Opulus and Dioscorea, ½ grain of Scullcap, 3 grains of

Cloves and 4 grains of Cinnamon. It contains about 85 per cent of Alcohol and 6½ per cent of Glycerin.

One of the chief functions of this combination is to quiet the movement of the uterus and to lessen the uterine flow. There is abundant testimony at hand to confirm the value of Viburnum in threatened abortion. Dr. Phares, of Mississippi, as early as 1866, ascribed to it valuable nervine, antispasmodic and tonic properties in the above conditions, and the present formula for the compound tincture yields what is possibly a most active and reliable therapeutic agent for these conditions.

It may at times be necessary to increase the amount of Viburnum in the preparation, and this is readily accomplished by the addition of the fluid extract. It sometimes causes nausea and vomiting, and in such cases, some other remedy must be substituted. It is best administered in hot water, preferably sweetened.

There are many proprietary "viburnum" compounds on the market under various fanciful names, and of somewhat similar composition to the above, but it is well to guard against their usage for several reasons. One is that their composition is an unknown quantity, and another is that the "original" package is as a rule accompanied by literature the reading of which is a natural and very prolific cause of self-medication on the part of the laity.

TINCTURA BELLADONNAE FOLIORUM, U. S. P.

Tincture of Belladonna leaves is an assayed tincture of definite strength representing ten per cent of Belladonna leaves in a menstruum of Diluted Alcohol. While it contains a definite percentage of alkaloids (.0003 per cent or 1 grain in 7 3-10 fluid-ounces), we would respectfully caution physicians that these alkaloids do not always represent the total value of Belladonna leaves as a medicinal agent. The natural combinations of the alkaloids with other principles as they exist in the leaf should always be reckoned with. However, these alkaloids, and especially Atropine, have their specific uses in medicine.

The pharmacological action of Belladonna is varied, thus indicating a very wide sphere of usefulness. It is employed in direct conformity with its pharmacological action, as follows:

Medicinal doses quicken the pulse and raise the arterial pressure; small doses increase peristalsis by paralyzing the inhibitory fibres of the splanchnic. It lessens all secretions except those of the kidneys and intestines.

This tincture is the best and most widely used preparation of Belladonna. This drug is one of the most valuable agents in the materia medica, ranking high in efficiency and its wide range of usefulness. The dose range is from 0.3 to 1.2 Cc. (5 to 20 minims).

Proceedings of Societies

CINCINNATI ACADEMY OF MEDICINE.

Meeting of February 25, 1912.

Dr. A. G. Drury, as chairman of the committee, read a short eulogistic history of the life and accomplishments of Dr. Thos. C. Minor, with resolutions on the death of Dr. Minor, which were adopted. Dr. Francis W. Dowling gave a short impromptu address on some personal characteristics and incidents in Dr. T. C. Minor's life.

On motion by Dr. Charles Caldwell and amended by Dr. Drury, the regular meeting night of March 11, 1912, was voted as a memorial meeting to Dr. A. B. Isham. This is to be the regular order of business for the evening.

The committee appointed to investigate the Medical Reform Institute, Inc., 1425-27 Vine Street, reported:

1. That the Medical Reform Institute is not incorporated, and cannot be incorporated under the laws of the State of Ohio. One of the forbidden purposes of an incorporation is the "conduct of professional business."

2. This concern is running essentially a medical service brokerage business, acting as middleman between patient and doctor, which your committee believes to be detrimental to the welfare of both the public and the medical profession.

3. This institute is particularly vicious in that it advertises as blatantly as the worst quack, and at the same time uses the names of reputable physicians to bolster up its business.

4. Your committee finds that many reputable physicians, and some of them members of the Academy, have permitted the use of their names without a full knowledge of existing conditions, and will no doubt withdraw all connection with the concern and forbid further use of their names, upon being properly informed.

5. Your committee recommends that evidence of services hereafter rendered by members of the Academy of Medicine for the Medical Reform Institute be submitted to the Board of Censors for action.

We wish to thank Mr. Paul Rover, attorney, for signal services rendered both here and in Columbus in this matter.

Respectfully submitted,

G. Strohbach,
Robert W. Thomas, *Secretary.*

CASE REPORTS.

Dr. J. A. Thompson reported a case, and presented the patient, with acute suppurative themoiditis with orbital cellulitis, Discussed by Dr. Charles Caldwell.

Dr. Jos. Ransohoff presented a patient with fracture of the femur, with several X-ray plates to show original deformity, and result of his unique and original method of treatment. Patient had two and a half inches of shortening, and to get proper amount of traction Dr. Ransohoff used a pair of ice tongs to grasp the lower end of the femur, so as not to require plaster, use a nail through the oscalcis, or Buck's extension, or do an open operation of Lane, using the bone plates. Ice tongs were applied just above the knee joint, and it required forty pounds weight to correct the deformity. Result of continuous extension was productive of a good result anatomically and functionally. Patient had little or no shortening and good motion of the knee. Dr. Ransohoff said that only a limited number of fractures should be treated by the open method, and then only by a thoroughly competent surgeon who was sure of his surroundings and technique; that bones situated deep were less favorable cases for bone plates than the more superficial ones. Dr. Charles Caldwell said that in his judgment the femur and deep-seated bones were quite as desirable risk for plating as the more superficial ones, and that infection was not always carried in, but might be due to cryptogenic type of infection from some focus of infection in a remote part of the body.

Dr. W. D. Haines agreed in the main with the ground taken by Dr. Ransohoff, and was conservative in his advice to use Lane's bone plates. A functional result was desired more than an anatomical one. Dr. Ricketts reviewed briefly the history of the open operations for fracture, and congratulated Dr. Ransohoff on his ingenious method of procedure in this case, and on the results he obtained. When men of Ransohoff's experience were conservative on these lines, it is well to select our cases very carefully. Dr. Ransohoff, in closing, asked if any one present had ever seen a simple fracture suppurate when treated by the closed method and ventured the statement that cryptogenetic infection did not occur once in five hundred cases.

Dr. B. M. Ricketts presented a specimen of ovarian hematoma, and held that these cases were less rare in his experience than found by most authorities. He also presented the specimen of a case of primary tuberculosis of the index finger, for which he did an amputation.

Dr. M. L. Heidingsfeld reported two cases: (1) Elephantiasis cutis penis, of twelve years' duration, and so extensive as to prevent the sexual act. The elephantiasis was due to extensive bilateral excision of the inguinal glands twelve years ago, for suppurative bubo from chancroid. (2) A case of extensive vegetating papular syphilides, in women where there was some tendency to lymph edema of the labia. He stated that this class of cases would respond more favorably to salvarsan than any other form of treatment. Both cases were illustrated with colored lantern slides. Discussed by Dr. A. W. Nelson, who said that ordinarily incision and drainage was sufficient in these cases, and only rarely was excision demanded. Drainage with cleanliness and antiseptic treatment was his practice.

Dr. M. A. Brown reported in detail two cases of cerebrospinal meningitis, type meningococcus intracellularis. One was treated with New York Health Board serum and the other with serum from a pharmaceutical house. Both recovered. Discussed by Drs. Frank Lamb and Ed Baehr. Dr. Baehr contended it was a surgical proposition largely, and that drainage and withdrawal of the purulent exudate from the cord was the keynote

in treatment. He agreed with Dr. Brown that washing out the canal was advisable. Laminectomy and temporary drainage in these cases was a justifiable procedure, and that as much or more benefit came from washing and drainage and salt solution as from the serum. He believed the condition was analogous to an empyema. Dr. R. W. Thomas called attention to the fact that these cases sometimes follow epidemics of influenza, and that as a prophylactic measure the nose, throat and accessory sinuses should have proper care and antiseptic cleaning. Dr. Brown, in closing, said that drainage did not cure the cases before the serum was discovered and used. Undoubtedly the relief of pressure by withdrawal of cerebro-spinal fluid was beneficial. He would not hesitate to wash out the cerebro-spinal space with saline, and rather favored giving larger doses of serum, even up to 40 to 60 cc. Pressure and cerebro-spinal fluid tend to recur from time to time when serum is not used. The colored race seems to be more susceptible to the disease than the white race.

Meeting of March 4, 1912.

The Secretary read a communication from the Business Men's Club, relative to national legislation on commercial use of phosphorus. The communication asked that the Academy take such action and recommend such legislation as will best protect the health of the laborers. This matter came primarily from organized labor, and was referred to the Academy by the Business Men's Club of Cincinnati. On motion of Dr. Schenck, the matter was referred to the Standing Committee on Legislation, Dr. J. C. Oliver, Chairman.

The regular paper of the evening was then read: "The Cystoscope as an Aid in Urinary Diagnosis and Treatment," by Dr. A. W. Nelson. Dr. Nelson reviewed the history of the instrument, and said efforts at its use were made as early as 1807, and showed a number of drawings to illustrate styles of instruments. To use the cystoscope with any accuracy and diagnostic skill requires long, patient study and experiment, and at least three types of instrument—direct, indirect and retrograde. Careful cystoscopic diagnosis frequently saves a patient the necessity of undergoing

a cystotomy or even a more serious operation. From an operative standpoint it has a rather narrow, but very distinct field. It comprises treatment of certain stone cases, foreign bodies, ulcers, irrigation of pelvis of the kidney in gonorrheal infection, and high frequency current in the treatment of papilloma and certain other forms of bladder tumors.

Dr. Gordon McKim, in discussing the paper, called special attention to the use of the cystoscope in the diagnosis of the so-called median bar of the prostatic region, which gives symptoms similar to true hypertrophy of the prostate, and which is best differentiated by means of a correct reading through the cystoscope; that by this means what might otherwise be considered a case for major operation was demonstrated to be amenable to minor surgery.

Dr. W. D. Haines reported a case of membranous pericolitis (Jackson), and said that since Jackson's report before the Western Surgical Association he had found four cases of this condition in his abdominal work. The cases presented in common a broad band or veil-like membranous adhesion from the colon to the anterior and lateral abdominal wall, which probably was the adhesion which was formed at some time during a true inflammatory peritonitis.

In discussion, Dr. Souther said that there had been two or three recent articles in the literature which were well illustrated and bore out Dr. Haines' cases. One of these cases was by L. S. Pilcher, of Brooklyn, in January, 1912, *Annals of Surgery,* one by Ginsburg, of Philadelphia, in October, 1911 *Surgery, Gynecology and Obstetrics,* and one by Connell, of Oshkosh, in November, 1911, *Surgery, Gynecology and Obstetrics.* These three papers are of sufficient importance to justly establish this condition as a clinical entity, and it is generally recognized that chronic constipation and obstipation and partial obstruction are fairly constant concomitant symptoms. Dr. Haines's method of dealing with the condition is in accord with the suggestions of Pilcher and others, and can be thoroughly endorsed.

Dr. Magnus A. Tate reported a case of suppurative appendicitis that did well for thirty-six hours, and then developed signs of anuria, which yielded promptly to Fischer's alkaline treatment. Dr. Tate was using the proctoclysis of ordinary saline, but the case developed the urinary symptoms in spite of this much-praised therapy. Substitution of Fischer's alkaline treatment was followed in four hours by renewed renal activity, and patient bids fair to recover.

Dr. R. W. Thomas called attention to a number of cases of anomalous appendices, one measuring twelve inches and extending down across the sacrum.

Dr. D. D. DeNeen presented a specimen of lower lobe of the right lung of a cat removed experimentally without intratracheal insufflation anesthesia with recovery.

Dr. Frank Fee presented a specimen of large stone removed from urinary bladder, and showed X-ray plate. In reporting the case Dr. Fee noted that the history showed stone symptoms for seven years, but the diagnosis had not been made because the stone was encysted and escaped the sound. Operation and removal was followed by recovery. Discussed by Dr. A. W. Nelson, who said that had the cystoscope been used the diagnosis would have been easy.

Dr. J. A. Caldwell reported a traumatic thrombosis of the brachial artery relieved by operation. Dr. Caldwell operated on his patient within a few hours of the injury, and by massage was able to cause the obstruction in the artery to disappear, and patient made a perfect recovery.

Dr. Moses Salzer read a paper on "Nitrous Oxide Oxygen Anesthesia as a Routine Anesthetic," in which he considered at length the advantage and disadvantages of the method, and made a plea for its more general use, on the grounds of its safety.

Dr. F. Hoefer McMechan ably discussed Dr. Salzer's paper, and said that, notwithstanding all of its advantages, there still was a mortality associated with its administration. He quoted a large number of statistics to bear out the statement, and said that alcoholism was a distinct contraindication to its use in nearly all cases.

Dr. Bonifield said that the breathing methods gradually coming into vogue were a reversion to the principle involved in the closed ether cone method, of which he is an advocate.

Dr. F. W. Dowling inquired as to the status of ethyl chloride in Cincinnati, and said that it was extensively used in France and worked well in throat cases and for short anesthesia.

Dr. Samuel Iglauer said that he had read a paper before the Academy in 1903 on nitrous oxide and ether. He believed nitrous oxide had a definite field, and should be used more extensively.

Dr. Salzer, in closing, said that while he would rather *give* ether, he would rather *take* nitrous oxide oxygen.

Meeting of March 29, 1912.

Dr. John E. Griewe presented a patient, boy of twelve years, seen in consultation and studied by X-ray pictures, showing an abnormally large colon and presenting symptoms of Hirschsprung's disease and obstipation. X-ray plates showed almost normal contraction of the colon in serial plates taken at intervals.

Dr. Jos. Ransohoff presented a patient who two years ago had a tubercular tenosynovitis, and in February, 1912, was operated on for apparent tumor of the cecum, the cecum and eighteen inches of ileum were removed for tubercular condition with ulcerated mucosa and tubercular peritonitis, with partial obstruction; complete recovery.

Dr. Robert Carothers presented a specimen of tubercular glands of the cervical region removed *en masse* from a lady twenty-two years old. Dr. Carothers stated that he saw less of these cases recently, since the throat men were performing the complete enucleation operation for the diseased tonsil.

Dr. J. Louis Ransohoff presented a similar specimen of tubercular glands of the neck, and stated that the dissection was greatly facilitated by the division of the sterno-mastoid muscle and its reflection up and down, laying bare the carotid region, and being able to see the vessels and better avoid them.

Meeting of March 12, 1912.

Dr. Frank U. Swing presented some very beautiful specimens of hookworms, male and female.

Dr. E. G. Zinke presented X-ray plates representing a high degree of coloptosis, as bearing on the paper of the evening.

Dr. Chas. T. Souther presented a patient upon whom he had performed a partial gastrectomy for cancer eight months ago. Patient is well, eating everything, and has gained twenty-seven pounds.

Dr. Henry L. Woodward presented as a specimen a baby, full term, hydrocephalic, with spina bifida and club feet. Delivery was accomplished by puncture of the spina bifida and rupture of the hydrocephalic head, after which delivery was easy.

Dr. John E. Greiwe presented the regular paper of the evening, "Ptosis of the Colon, Its Relation to Neurasthenia and Auto-Intoxication" (with X-ray plates). Dr. Greiwe's description of the condition, its clinical side, the relation of constipation in childhood as an etiological factor, the difficulty of absolute diagnosis, the necessity of serial X-ray pictures at short intervals as a valuable aid in the estimation of the condition or tone of the intestinal musculature, were very instructive, interesting and conclusive. *The Bulletin* can in no sense do justice to the very commendable article in extract. Dr. Greiwe's conclusions were conservative and most excellent. His conclusions from X-ray study would indicate that this is a very valuable means when properly used, and misleading if not oft repeated and properly interpreted.

Dr. Frank Rattermann, in opening the discussion, cited cases in his work to bear out the position taken by Dr. Griewe, and called attention to the relative limit of medical treatment as anything more than a palliative measure. He was inclined to divide the cases into groups where medical, mechanical and surgical treatment was indicated.

Dr. C. A. L. Reed said we are now repeating the observations and conclusions of Glenard, of some twenty years ago, and that his descriptions have to this day not been improved upon. We

are approaching this very important subject step by step, and may say that we began by attacking the loose kidney; later less kidney work has been done, and we are paying more attention to the general visceroptosis with special attention to the colon. The logic of Dr. Greiwe is irrefutable and his conclusions are good. The colon is frequently the primary offender, due to ptosis and angulation causing redundancy. A very redundant cecum has been observed in a number of recent cases. Fixation of the cecum in these cases has given good results. In the markedly atrophic colon the Lane short circuit operation is indicated. In the dilated, adherent or misplaced colon the fixation operation is indicated.

Dr. Robert Carothers said he had first seen this condition operated on twelve years ago by the hammock operation, and six years ago he saw a case with Dr. Caldwell in which they operated by a similar method, with very good results, lasting in character. He said that his attention had been further called to this condition by the work of Goldthwaite, of Boston. In a limited number of cases his results were good, with mechanical treatment. Usually these cases have a general lack of tone in the entire system, especially the ligamentous and osseous systems. They have flat feet, loose joints, etc. We are yet in our infancy in the care and treatment of these cases, and should go very carefully and select our cases so as to make very few if any mistakes.

Dr. Ralph Reed took exceptions to the use of the term neurasthenia in these cases, saying that neurasthenia was a neuron fatigue and a distinct entity, and unless so considered we must refute the teachings of all the best neurologists the world has known.

Dr. W. D. Haines called attention to the etiology, and said that until we can be more definitely causal in our surgical therapeutics we cannot hope to make much progress. Muscular relaxation and relaxation of pelvic outlet are factors in the production of symptoms, and further that there were too many remedies for any of them to be of value. Glenard said that "we may have a colon ptosis without a kidney ptosis, but never a nephroptosis without a coloptosis."

Dr. Ed S. Ricketts said that it would be well to show some X-ray plates of cases that had been operated.

Dr. J. E. Pirrung said he had been with Mr. Lane, and had examined the first case he operated, and that the patient gained greatly in weight and was well. Practically all the cases gain in weight and lose their sallow skin and auto-intoxication. Most cases are unmarried women. He does not believe that rest, massage and mechanics mean much in these cases.

Dr. Max Dreyfull said some married women were relieved during pregnancy, only to have the condition return after confinement.

Dr. Greiwe, closing, said, in reply to Dr. Ricketts, that he had some pictures of post-operative cases, but that Dr. Lange had overlooked them. In answer to Dr. Haines' question, he said that constipation in childhood was a decided factor in the etiology, and on its prevention and cure depended our greatest prophylactic measure. Evolution, *i. e.,* change from quadruped to biped, was a factor. He used the term neurasthenia to mean nerve fatigue due to toxic condition, and that it was an anatomical and mechanical condition.

Selected Articles

CARDIOPATHIES COMPLICATING PREGNANCY AND LABOR.*

BY A. SAMUEL, M.D., *Baltimore, Md.*

In order to be able to give a relative prognosis and to treat and manage pregnant patients with cardiopathies, it is quite necessary to study (1) the effect of normal pregnancy upon the normal heart; (2) the effect of dystocia upon the normal heart; (3) the effect of pregnancy and labor on the diseased heart; (4) the effect of cardiac disease on pregnancy; (5) the consideration of the question of inducing premature labor in patients with heart disease; (6) the management of labor; (7) the problem of matrimony for sufferers of a heart lesion.

In normal labor there is an increase in the size of the heart. This hypertrophy is the result of a prolonged increase in work, which is probably due in part to the dilation of the heart, and in part only suggested by the increased area of dullness, resulting from the change in the position of the heart. This change in the position of the heart is caused by the growing uterus gradually pushing the diaphragm upward, causing the heart to assume a more transverse position. The apex is not infrequently found in the fourth interspace. James MacKenzie has shown that the dilation during pregnancy affects the right heart more particularly, and that in very many cases even of otherwise normal women a definite insufficiency of the tricuspid valve may appear, disappear and reappear, and the presence of this insufficiency is shown by the positive venous pulse and the systolic murmur in the tricuspid area. This probably accounts for the appearance of accidental, non-organic murmurs during pregnancy. Various theories have been offered in explanation of this phenomena. The latest theory is that the murmur is caused by a slight kinking of the large vessels, especially the pulmonary artery, as a result

of the peculiar dislocation of the heart during pregnancy. It is obvious that special care must be taken in the differentiation of this accidental murmur from one produced by a mitral insufficiency.

II. THE EFFECT OF DYSTOCIA UPON THE NORMAL HEART.

With the introduction of reliable and practical instruments for measuring the blood pressure, great interest has been awakened in the question of the effect of a pathological pregnancy upon the cardiac function. As stated before, the blood pressure in a normal pregnancy and a normal heart was found to be between 118 and 126. In cases of eclampsia, the blood pressure may vary anywhere between 130 and 120. In patients with impending eclampsia, the blood pressure increases markedly, and falls after delivery, when the symptoms subside. In very grave and fatal cases there is an extreme increase in pressure. In edema particularly, the pressure seems definitely related to the type of the case; therefore, its observation is of value in prognosis and treatment. In cases of chronic nephritis, with symptoms of toxemia, the blood pressure remains very high, even after the symptoms have been relieved by delivery.

III. THE EFFECT OF PREGNANCY AND LABOR ON THE DISEASED HEART.

The old writers have no doubt exaggerated the dangers of pregnancy and labor upon the diseased heart. Cardiac disease at one time was looked upon as one of the most serious complications of pregnancy, and many eminent physicians claimed that about 40 per cent of women with serious heart lesions met their death in connection with child birth. While it is extremely difficult to arrive at any definite figures as to the mortality, since Fellner at Schauta's Clinic claims that a heart lesion is not recognized in more than about 14 per cent of patients, and that in 86 per cent of these patients suffering with cardiac complication to pregnancy it is overlooked because the cardiac symptoms do not become manifest, I have had two deaths in 12 cases, one of these occurring immediately at the termination of labor, and the other

three weeks afterwards. If possible, it is rather important that all patients should be thoroughly examined, in order that the cardiac complications may be detected, for more reasons than one—firstly, operative methods may become necessary to quickly terminate labor to prevent a fatality, and secondly, since the introduction of the Momburg belt constriction, the application of the belt is strictly contraindicated in the presence of any form of heart disease.

During pregnancy minor cardiac lesions are rather difficult to detect. Early signs of break in compensation may also be difficult to detect, since there is a change in the position of the heart, changes in the area of dullness, changes in the pulse rate, blood pressure and frequently accidental murmurs, or even physiological relative tricuspid insufficiency of muscular origin. Edema of the lower extremities and of the genitalia may be caused solely by the pressure of the heavy uterus against the heavy pelvic veins. The diagnosis of a decomposition during pregnancy depends, however, upon signs that are relative rather than absolute. Dyspnea and cyanosis on very slight exertion, such as quietly walking a few hundred yards, walking up a few stairs, the presence of a small, rapid pulse, persistent cough, enlargement of the liver and edema of the legs may be regarded as the most important symptoms. It may also be said, the earlier in pregnancy these symptoms occur, the more alarming they are. Statistics of the fatalities to mother and child are valueless, some authorities claiming an overwhelmingly high mortality to both mother and baby, while others place the mortality ridiculously low. I think we must all bear in mind that cardiac lesions are all more or less dangerous, and the successful outcome of both mother and child does not depend so much upon the lesion present, but to the condition of the myocardium. Valvular lesions seem to be the least dangerous; stenosis, mitral stenosis and chronic myocarditis, due to infection or intoxication, the most dangerous. The most serious consequences have been noted in first labors. This is explained probably by the difference in duration and the severity. For patients who have had several breaks in compensation dur-

ing their pregnancy, without the proper rest and care, prognosis is distinctly grave, both to the mother and child.

The greatest dangers arising from cardiopathies in pregnancy are degenerative changes in the myocardium. It must be borne in mind that heart failure is essentially a question of the integrity of the heart muscle, and this I should like to impress upon you, as in the treatment of the various forms of cardiac failure it is the integrity of the cardiac muscle which we have in every case to consider. While in the great majority of cardiopathies a valvular lesion is only an embarrassment to the heart in its work, and one which may be easily overcome, the presence of a lesion, however, is important in that it calls attention to the heart, and may remind us that the disease which has injured the valve may also have injured the muscle. Our object first is always to find out in these patients the extent of the lesion to the muscle, and how far the valvular lesion involves the muscle. In valvular lesions with little or no enlargements of the heart and a fair response to increased force, pregnancy and labor may be without terrors. If response is limited, if palpitation is readily induced by exercise, opinion should be suspended until the result of treatment is ascertained. If the condition is not improved, then the outlook is not so hopeful. It must be kept in mind, however, that some persons with valvular lesions may suffer from most severe heart failure and make good recoveries; in fact, I have in mind one of my patients who has had five children, and who has had at least 10 or 12 attacks of heart failure. During her last pregnancy she had a most severe attack of decompensation two weeks before the baby was born, yet she made an uneventful recovery, and is still living.

Mitral stenosis is more dangerous than mitral insufficiency; at least I have found it so, as I have never lost a case of mitral insufficiency during or immediately after labor, whereas I have had one death from mitral stenosis. In talking this matter over with several other obstetricians, several of them have lost cases of mitral stenosis, whereas their mortality has been nil with insufficiency. Probably the greatest complication of parturition for the mother and child is acute edema of the lungs. The resulting

asphyxiation of the mother invariably leads to the intrauterine death of the foetus. The two greatest dangers arising from the complication of a heart lesion with pregnancy are break in compensation already referred to and degenerative changes in the myocardium, with subsequent cardiac failure. One must not overlook the fact that the patient is not out of danger after delivery, for symptoms of severe heart failure may supervene any time within the next three or four weeks. In one of my patientst with a mitral insufficiency who had comparatively easy and spontaneous delivery and showed no signs of cardiac embarrassment three weeks after delivery she had a bad break in compensation, and died 24 hours afterwards.

THE EFFECT OF CARDIOPATHIES UPON A CO-EXISTING PREGNANCY.

We find the most pronounced expression in premature expulsion of the uterine contents. Statistics on this point as to the relative frequency of premature spontaneous termination of the pregnancy are very unreliable. However, it may be stated with safety that it occurs in about 25 per cent of all the patients with a cardiac lesion. Premature termination of the pregnancy does not take place unless there is some break in compensation. Various causes have been ascribed. Congestion of the endometrium, due to circulatory disturbances, apoplexies of the placenta or hemorrhages between the placentat and decidua, interfere with placental respiration or the defective oxidation of the maternal blood may cause death in the uterus to the fœtus from asphyxiation.

Consideration of the question of premature delivery in patients with cardiac disease is still an open one. It cannot be denied that the greatest dangers to the mother develop during labor. In women whose compensation is good, who can stand a moderate amount of strain without showing signs of fatigue, it may be safe to allow the patient to go on to term; but if a break in compensation occurs at any time during her period of gestation, it may be well to consider the question of producing abortion. This is a grave question, and should not be undertaken unless the family and another physician are called into consultation. With quiet

and rest in bed, many of these patientst who have had breaks in compensation may go through labor without the least bit of embarrassment, whereas if we had terminated pregnancy, the child would have been lost. We must not lose sight of the fact that the production of premature delivery produces almost as much strain on the patient as at full term, except that it may be shorter. The loss of blood in these patients is more beneficial than harmful, and should not be considered a factor contraindicating premature miscarriage in cardiopathics. However, when we decide to terminate pregnancy, the method employed should be one that produces the least amount of strain on the patient. In three of my cases the question of terminating labor was carefully considered. One patient in particular had a bad break in compensation about the seventh month. This patient was put to bed, absolute rest, on light, nutritious diet, and the infusion of digitalis in tablespoonful doses given. After a three weeks' rest in bed she showed no further signs of a break in compensation. Notwithstanding her labor was quite long, she showed no cardiac embarrassment. I should say that with patients who showed signs of a break in compensation about the sixth month of pregnancy, and did not regain compensation after three or four weeks' rest in bed, with the use of the customary medicinal and therapeutic measures, and if the same patient after this rest in bed again showed signs of decompensation, the question of terminating pregnancy should certainly be considered. Of course, in desperate cases, where the patient is moribund, with the prospect of saving the child, the prompt induction of labor should be atttempted, though this in many instances is rather useless, as by the time the baby is born it is already dead from asphyxiation.

As long as the compensation is good, the patient should merely be carefully watched. No medicines need be given. The old practice of giving tincture of digitalis and strychnine many months before labor is really of no benefit. When nature is taking care of the heart—and this is shown by a good compensation —medicine is not called for. The only time that medicine should be given is in breaks of compensation. At the first signs of a cardiac weakness, the usual remedies, such as digitalis or stroph-

anthus, should be given. Ordinarily I use a preparation of digalen in from 8 to 15-drop doses. If an immediate effect is required, I give this hypodermically. Some physicians have recommended the giving of digitalis or strophanthus at the beginning of labor. I have tried this in several patients, and have not seen that these patients did any better than those who had not been given digitalis. However, there is one preparation that is most useful in these cases at the beginning of labor, especialy in primipara, and that is morphia in quarter-grain doses, and at sufficiently frequent intervals to procure the quietude of the patient. Morphia in these cases does not stop the labor pains, but gives the patient rest, and she does not exert herself, lessening the strain upon the heart. I have never found any ill effects from the use of morphia.

At the clinic of Schauta, in patients with mitral stenosis, pregnancy is terminated as soon as the slightest signs of broken compensation appear. This probably accounts for their low mortality in this class of patients.

In the management of labor in these patients one must be particularly careful. If the slightest signs of heart failure appear the patient should be instructed not to bear down. The usual heart stimulants may be given, combined with a quarter of a grain of morphia, and, if the first stage of labor is over, forceps should be applied and the woman delivered as quickly as possible. The question of giving an anesthetic in these patients is an open one. MacKenzie says he has never seen a fatality from the use of chloroform, while Hirschfelder advocates ether. In several of my patients, where it was necessary to deliver with forceps, I have used ether, with little or no bad effects. With one patient compensation began to fail at the end of the second stage of labor. I gave her several quarter-grain doses of morphia, and applied forceps and delivered her practically without pain. If the signs of heart failure make their appearance early in labor, with the cervix partially dilated, the outcome may be serious. Here you may have to anesthetize the patient, forcibly dilate the cervix and deliver with forceps, or resort to version. Version is a particularly dangerous operation when not performed by one thor-

oughly experienced in this line, as the danger of rupturing the uterus is very great; and, besides, with a cervix that is not completely dilated, a great deal of difficulty may be experienced in delivering the child, thereby throwing extra strain upon the patient by keeping her unnecessarily long under an anesthetic.

Patients with a pronounced dyspnea feel more comfortable in a high, reclining position during labor. In one of my patients the dyspnea was so great that she practically sat up in a chair during the whole period of her labor; in fact, the child was delivered with the patient seated in a large chair.

The application of heavy sand bags to the patient's abdomen during the first stage of labor and soon after the baby is born—this being done (1) to accelerate the dilation of the cervix by keeping the baby's head well against the cervix, and (2) to prevent the large abdominal vessels from suddenly filling—is a method that I have not used. To prevent the abdominal vessels from filling, probably the best way is to place the patient in bed and raise the foot of the bed to an angle of 45 degrees. If the pulse should become irregular, and especially if there is evidence of a dilation of the right heart in the third stage of labor, postpartum hemorrhage should be encouraged. Ergot is more or less contraindicated in these cases of cardiopathies complicating pregnancy, for the reason that the slight bleeding after delivery of the child is decidely beneficial to the patient, and particularly where there is evidence of a right heart dilation.

Operative procedures should be taken with caution, and never without the consent of the family, and another physician should always be called in consultation. In view of the possible grave danger of asphyxiation attending pulmonary edema, the obstetrician should be ready to hasten delivery by instrumental measures. The giving of salt solution in these cases should be done with caution, and it should be given in fractional doses; probably the Murphy's drop method by rectum is the best method to give the salt solution. It should never be given intravenously. Asphyxiation is best treated by immediate venesection. In view of the fact that serious complications are liable to follow later, I always advise against the mother nursing her child, as the arti-

ficial feeding of the baby insures the mother more quiet and rest. Of course, if the mother offsets these advantages by mental anxiety and worry at not being able to feed the baby, it may be necessary in these few cases to allow the child to be breast-fed. In artificially feeding these children many difficulties are encountered, because so many of these children are born in a weak and frail condition, and when artificially fed the mortality is extremely high.

I have had but one patient suffering with exophthalmic goitre complicating pregnancy, and I hope I will never be called on to treat another case. This patient had quite a large thyroid, with the usual symptoms of Graves' disease. Of particular interest was her pulse beat. Prior to labor, the pulse averaged between 140 and 160 per minute. During the first stage of labor the pulse beat was 170. At the end of the third stage her pulse beat was about 190, and then it became so fast that I could not count it, while the rhythm was not disturbed and the sounds were clear. Immediately after the birth of the child she had an attack of syncope, and during this attack I could not count her pulse at all. Signs of acute pulmonary edema rapidly set in, and the rales and rattling could be heard almost in the next room. During all this excitement she began to bleed most profusely, before the placenta was delivered, and it was necessary to deliver the placenta quickly, in order to stop the bleeding. In the meantime, the baby had become asphyxiated and had died, and it looked as if the patient would follow within a short time. This rapid pulse rate continued for three or four hours, and almost every minute the edema seemed to increase. I gave her the usual heart stimulants, but they were without avail. After the heart stimulants failed, I resorted to the use of morphia, and this seemed to act like a charm. It immediately quieted her nervous condition, and, while the heart beat did not lessen, yet she was very much more comfortable, and the heavy pressure which she complained of in her chest was almost immediately relieved. After the patient remained in this condition four or five hours, I gave her another dose of morphia, and she went to sleep for two hours. During her sleep the pulse gradually dropped in the number of beats per minute. By the

next morning her pulse beat was about 135, with fairly good volume, and she complained of little or no pain. Her condition gradually improved, and about the third week she sat up for the first time. I strongly advised this patient not to become pregnant again, and to have her thyroid gland removed.

When we consider the great dangers of cardiopathies complicating pregnancy, the question naturally arises—whether women with heart disease should marry. This is by no means a settled question. We all know that when heart disease is complicated with any condition that throws an additional strain upon it, it endangers the patient's life. However, matrimony and pregnancy are not identical terms, and we do know that the great majority of women with good compensation go through pregnancy without any noticeable ill-effects. Marriage to many girls means an improvement in their social condition. It may mean a life of comparative ease as compared with the possible necessity of earning a livelihood by work. These are factors worth considering when the physician is asked the question whether a girl with a cardiac lesion should be permitted to marry. Indiscriminate denial of marriage to all women having valvular lesions may imply an injustice to many of them. In all cases of valvular lesion, heart failure may occur sooner or later, but it is an open question whether its onset will be precipitated by child-bearing, and it is doubtful if the risk of this is so marked as to justify denying her the right to marry. I should say, however, in women who have a heart lesion, with concomitant pulmonary or renal disease, one should advise against marriage. In view of the high death rate of mitral stenosis, one should be very cautious in advising marriage for these women.—*Maryland Medical Journal.*

Extracts from Home and Foreign Journals.

SURGICAL

Diagnosis of Appendicitis.

Blumberg (*Berl. Med. Ges.,* Oct. 27, 1909, through *Wien Med. Woch.* 1910, No. 17) describes a new symptom of appendicitis and peritonitis, consisting in a severe pain which is produced by the sudden removal of the hand that has been pressing upon the abdomen, if the peritoneum is affected. On the sudden removal of the hand the elastic peritoneum is suddenly returned to its position. If it is normal, no pain occurs, if it is inflamed, intense pain follows. This method renders an early diagnosis possible, but it does not enable us to make a differential diagnosis between appendicitis and disease of the uterine appendages.—*The American Journal of Clinical Medicine.*

End Result of Operation in Graves' Disease.

Dr. G. W. Crile (*South. Med. Jour.,* Feb., 1912) states that since conducting operation on the new principle of anoci-association, and recognizing the importance of Kocher's progressive elimination of glandular activity, the mortality has all but disappeared, excepting in those that are potentially dead at the time of operation. Recent statistics of all cases will amount to about two deaths in one hundred. As to the end results, when the disease is of long standing in patients of poor physical structure, and whose financial and social circumstances permit of no mitigation of the strain of life during the time of convalescence, the results are correspondingly impaired. No patient died of the disease after leaving the hospital; one was made worse by the operation; otherwise every patient was either benefitted or cured. Among the factors that influenced the end results were

the environment of the patient, the freedom from nervous shocks, the means at hand for diversion, as well as the avoidance of strain and the elimination of all nervous shock at the time of operation. The improvement began usually the next day after the operation, and continued for from six months to two years. The author regards patients as cured when they are able to withstand nervous shocks, such as fright, disappointment, worry, grief in a normal manner.—*International Journal of Surgery.*

Treatment of Stone in Ureter.

Not all cases of stone caught in the ureter will require operative removal, as is shown by the case reported by F. Weisz. The patient showed all the typical symptoms and on passing a catheter into the right ureter, a resistance could be detected two or three cm. above the vesical orfice. Ten cc. of sterile, warm glycerine were injected into the ureter with the result that the calculus was promptly voided. A second, larger stone was soon mobilized, but became caught in the fossa navicularis so that a meatotomy was required to extract it. The patient has remained free from symptoms ever since.—*The Medical Brief.*

Surgical Suggestions.

A breaking-down sarcoma of the ilium may simulate a gluteal aneurism.

Not infrequently subacute inflammations of the Fallopian tubes will be found to be of tuberculous origin.

A mild degree of shock causes an increase in leucocytes; severe shock paralyzes the leucoblastic function.

A pulsating tumor in the side may be an aneurism of the abdominal aorta, although palpation fails to disclose its connection with the aorta.

Before performing esophagotomy for foreign body, make a final examination (radiographic or otherwise) to determine that the object has not slipped into the stomach.

Persistent dyspareunia, with no other ascertainable cause, may often be found to lie in a chronic gonorrhea of Skene's duct.

Some apparently inoperable carcinomata of the cervix will yield remarkably to repeated cauterization with the actual cautery and zinc chloride.

Any menstrual irregularity or abnormality in a woman who has hitherto been perfectly regular and normal in her menstrual periods, should always suggest the possibility of an ectopic pregnancy.

Injection into a fistula in ano of a staining solution or a colored paste makes it possible for the operator to assure himself that all branches of the tract have been explored.

It is worth while inaugurating the treatment of "idiopathic" pruritus ani by the administration of santonin or of enemata of quassia infusion—seat-worms may escape discovery on one or two examinations.

If skiagraphs show the shadow of a calculus at the neck of the bladder when the patient is exposed lying flat with the organ empty, and in the same position when the pelvis is elevated and the bladder full, the stone is in the prostate (or prostatic urethra) or in a diverticum behind the prostate. (American Journal of Surgery.)—*Journal-Record of Medicine.*

OBSTETRICAL

Intramuscular Injection of Blood.

In many gynecological operations, particularly in fibroids of the womb, an operation is imperative, yet the exsanguinated condition of the patient is so marked that every interference is attended with grave dangers. Tonics act too slowly and transfusion is difficult, and not always possible. For these cases, P. Esch recommends the intragluteal injection of defibrinated human blood. The amounts employed were 15 to 30 cc. and local or general reaction was never seen. In one case the hemoglobin

rose from 25 per cent to 36 per cent in 13 days and in another from 23 per cent to 39 per cent in 12 days. Good results were also seen in pernicious anemia, and it may be an advantage to give larger doses here. In many cases bleeding was checked soon after injection.—*The Medical Brief.*

Ovulation and Child-Bearing Without Menstruation.

Two sisters, who had never menstruated but had raised families of children without any evidence of menstruation in their history, are reported by O. F. Blankenship, Richmond, Va. (*Journal A. M. A.*) One woman had three children; the other had been married three times and had eight. These are the only instances he has observed of child-bearing without any history of menstruation, out of many thousands of patients interrogated of examiners for life insurance companies and otherwise.—*The St. Louis Medical Review.*

Effect of Atropine on Pregnancy.

Dr. G. Mueller (noted in *Wien. Med. Woch.*, 1911, No. 47, 3026) reports the case of a woman 25 years old, who, in her third pregnancy, took an overdose of belladonna. At the end of the seventh month this woman drank a tea containing leaves, stems and berries of atropa belladonna, and she became ill, there being vomiting, disturbances of vision, and hallucinations. After recovery, the fetal movements became feeble and finally ceased. At term a dead child was born, the placenta showing signs of protracted retention, containing numerous lime incrustations and showing obliteration of all branches of the choroidal vessels.—*The American Journal of Clinical Medicine.*

Repeated Miscarriages.

I wish to report a case, thinking it may be of interest to some of your readers and perhaps call forth some suggestion as to the underlying condition. The patient, Mrs. R., aged forty-

six, Hebrew, has always enjoyed quite good health except as herein described. At about twenty years of age she had a miscarriage at four months, and since that time at irregular intervals miscarriages or premature births have occurred, varying from two and one-half to six months of gestation. The last miscarriage occurred in December, 1911, at about two and one-half months, this making the fifteenth pregnancy. Except once she never has gone beyond the sixth month. In only one instance was a child born alive, this at five and one-half months, but it lived only a few minutes. Only twice have I been able to examine the fetus, which showed nothing abnormal.

This woman has a chronic interstitial nephritis of some years' duration; this condition has been suggested as an underlying cause in this case, but it could hardly be presumed that this nephritis existed at the time of her first miscarriages. The Wassermann reaction was negative. Pelvic examinations show no abnormality suggesting a cause for these miscarriages.—*International Journal of Surgery.*

The Relation of the Thyroid Gland to the Female Generative Organs.

From a very interesting study published in the Canada Medical Association Journal, Drs. James R. Goodall and L. C. Conn draw the following conclusions: 1. The relation between the female genitals and the thyroid is very intimate. 2. The generative organs which stand in such close relation with the thyroid are the ovaries. 3. That the uterus is devoid of any influence upon thyroid activity, except in that its function may affect the ovarian function and through this the thyroid. 4. Thyroid activity is in a measure under the governance of ovarian activity. 5. Ovarian hyperactivity is a frequent cause of the development of exophthalmic goitre. 6. Diminished, or absent, ovarian activity usually coincides with myxedema. 7. Puberty, menstruation, pregnancy, lactation, and menopause, exercise a profound influence upon thyroid secretion. 8. Thy-

roid secretion and ovarian secretion do not supplement each other; they neutralize each other. 9. The ovary has two secreting structures—the corpora lutea and the interstitial cells. It is the secretions from the latter which seem to bring the ovary and thyroid into such close relation.—*The Medical Fortnightly.*

MEDICAL

Cerebrospinal Meningitis.

The recent discovery of the fact that the natural habitat of the organism of cerebrospinal meningitis is the nose and throat is considered by H. T. King, New Orleans (*Jour. A. M. A.*, Feb. 10), to be the most important contribution to our knowledge of the prophylaxis of the disease. With this fact also should be considered the discovery that the disease is carried from individual to individual, often by healthy carriers. The theory of direct extension from the nose and throat to the brain is untenable. The blood-route must be the one followed. In many cases the organism has been found in the blood, and it seems to have a special affinity for the meningeal tissues. There must be, however, some lowering of tissue resistance or increase of virulence of the organism, and the cause of this may, in some cases, be a trauma. The disease is undoubtedly transmitted directly from individual to individual and the number of persons carrying the infection is much greater during an epidemic than the number of patients. King estimates that nearly one-fourth of all individuals of the infected locality may be carriers of the disease without apparently showing any serious symptoms. Only occasionally do they present signs of a nasal pharyngitis or slight meningococcal infection. There are some persons who probably carry the germs permanently and perpetuate the disease. Up to the present there has been no absolutely efficacious means of causing the disappearance of the germs in the carriers, but the rigid observance of certain precautions would

limit the extent and severity of epidemics. The first essentials for this are: 1. The earnest co-operation between the people and the health authorities in enforcement of all necessary health regulations. 2. The detection and isolation of healthy germ carriers. 3. Efforts toward rendering them harmless. Thorough sanitary inspection is necessary and attention to soil pollution, especially in rural districts. Particular efforts should be made to destroy all germ-carrying parasites and vermin. Circulars of information should be distributed, school inspection should be thorough and popular lectures will also be useful. A carrier once recognized should be put under the care and observation of the health authorities and treatment directed toward disinfection of the nose and throat. All carriers should be inoculated with the anti-meningococcal serum. The results should be constantly tested bacteriologically and oral and nasal hygiene be made a routine, not only with them, but with others. Fomites, such as vessels, spoons, handkerchiefs, etc., which have become infected should be thoroughly sterilized or destroyed and special directions as to spitting, sneezing and coughing be given to all carriers of germs. By these means we may hope to minimize the effects of the disease when it occurs.—*The Medical Fortnightly.*

Vomiting in Infants.

H. Lowenberg, Philadelphia, remarks that as a cause for vomiting, congenital pyloric obstruction is too rarely recognized. All cases of vomiting beginning at birth or shortly thereafter and continuing in spite of a reasonable amount of food manipulation, especially in breast-fed infants, or in artificially fed ones as well, and associated with evidences of malnutrition, are to be regarded as cases of pyloric obstruction, until it can be proved that they are not. Vomiting, propulsive in character, occurring immediately, but more often from one-half to two hours after, the taking of food or drink, sour and fermented as a rule, accompanied by visible peristaltic waves in the epigastric region,

not necessarily reversed, with evidences of gastric dilation and intestinal collapse, with partial or complete constipation, with or without a palpable pyloric tumor and a varying degree of emaciation depending upon the duration of the case, is usually indicative of complete or incomplete pyloric obstruction, and calls for treatment other than the usual medicinal or dietetic remedies. If complete obstruction can be proved, and it often can, surgery, usually a posterior gastroenterostomy, offers the only hope. If incomplete obstruction or pylorospasm be the cause, evidenced by partial constipation and stationary weight, lavage, gavage, rectal feeding and the bromides may accomplish a cure.

In direct opposition to this fatal type of perisistent vomiting should be mentioned a type of persistent vomiting or "spitting up" of an entirely benign nature. This occurs in either perfectly healthy breast-fed or bottle-fed babies who persistently continue to thrive and to gain in weight. An adequate explanation for its occurrence is difficult or almost impossible of determination, and no treatment seems to be of avail. Dietetic manipulations usually give no help, and, as a rule, do harm by interfering with the infant's nutrition, making the weight stationary or causing a loss. It continues until it is spontaneously arrested. The breast-fed milk, by repeated analysis, is found perfectly normal. While a cause for it undoubtedly exists, the most plausible explanation is a vicious habit, which, perhaps, has its origin in faulty hygiene. The condition may be only cautiously diagnosed, and a good prognosis given when all other probable causes have been entirely excluded.—(*Journal A. M. A.*, January 20, 1912.)—*Virginia Medical Semi-Monthly.*

Editorial

PUBLISHER'S NOTICE—The Journal is published in monthly numbers of 48 pages at $1.00 a year, to be always paid in advance.

All bills for advertisements to be paid quarterly, after the first insertion of the quarter.

Business communications, remittances by mail, either by money order, draft, or registered letter, should be addressed to the Business manager, C. S. Briggs, M. D. corner Summer and Union Streets, Nashville, Tenn.

All communications for the Journal, books for review, exchanges, etc., should be addressed to the Editor.

THE TENNESSEE STATE MEDICAL ASSOCIATION.

The seventy-ninth annual convention of the Tennessee State Medical Society at Chattanooga, has just closed after one of the most successful meetings ever held. There were some 250 visitors from over the State, as well as quite a few guests from other States.

The papers read were scientific and interesting and so freely discussed that the program as outlined could not be completed. The evening of the first day was devoted to a smoker and vaudeville performance at the Hotel Patten, which was one of the most delightful entertainments ever given the society, and the afternoon of the last day was spent in motoring and sight-seeing.

Nashville was chosen as the place of meeting for next year, and the day was changed from the first Tuesday in April, which has been the date heretofore, to the last Tuesday.

The following officers were elected for the ensuing year: President, Dr. O. Dulaney, Dyersburg; Secretary, Dr. Perry Bromberg, Nashville; Vice-Presidents (East Tennessee), Dr. W. J. Matthews, Johnson City; (Middle Tennessee), Dr. Zell Shipley, Cookeville; (West Tennessee Dr. G. R. Livermore, Memphis Councilors, Drs. C. P. Fox, Greeneville; A. F. Richards, Sparta; Guy Frierson, Shelbyville; L. E. Ragsdale, Columbia; E. T. Haskins, Newbern; Delegates to the American Medical Association, Drs. A. B. Cooke, Nashville, and S. M. Miller, Knoxville.

OUR PREMIUMS.

We again desire to call attention to our premiums—a reliable clinical thermometer in case with chain attached, and a year's subscription to *Successful Medicine,* given to every new subscriber of the NASHVILLE JOURNAL OF MEDICINE AND SURGERY. We also offer the thermometer to every delinquent subscriber who pays his back subscription and renews his subscription for another year. This offer holds good for sixty days from date. To those who receive sample copies of the JOURNAL, together with circular letter, we suggest that they at once fill out the subscription blank furnished with the circular and enclose check or money order or bill for $1.00, mailing to our address, and the thermometer and receipts for subscription to this JOURNAL and to *Successful Medicine* will be promptly sent. We shall send statements to all our old subscribers who are in arrears in a short time, and unless the accounts are settled promptly we shall drop their names from the mailing list and turn over the accounts to a collecting agency. Our circulation has increased fifty per cent in the past six months, and we intend to add several thousand more names to the list during the year. We ask the help and co-operation of all physicians in the South to support with their patronage a journal of and for the South, operated as an independent medicine journal continuously from its establishment by the late Dr. W. K. Bowling in 1851.

SURGICAL CLINICS OF JOHN B. MURPHY.

We wish to call attention of our subscribers to the initial number of "The Surgical Clinics of John B. Murphy, M.D.,'" which we have briefly reviewed in our Book Notice Department. We feel that the W. B. Saunders Company have entered upon an undertaking which will be beneficial to the profession and themselves alike, and we wish them all kinds of success.

No man doing surgery can afford not to subscribe for these

books which contain the thoughts of one of the foremost surgeons in the world.

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Dr. Murphy is not only a surgeon, but he stands out preeminently as a teacher, and those who read these papers will necessarily learn much that will help them in their work.

Battle & Co. have just issued No. 18 of the Dislocation Charts, which completes the set. They will be sent free to physicians on request; also Fracture and Tumor Charts, if desired.

Reviews and Book Notices

Funk & Wagnalls Company have secured the American rights to "A System of Surgery," edited by C. C. Choyce, Dean of and Teacher of Operative Surgery in the London School of Clinical Medicine (Post-Graduate), etc. J. Martin Beattie, Professor of Pathology and Bacteriology and Dean of the Faculty of Medicine in the University of Sheffield, is the Pathological Editor of this important new work. It will be published in three octavo volumes and profusely illustrated with colored, black-and-white, and text illustrations. Each branch of surgery is treated by the foremost specialists in that particular branch in Great Britain, so that the work will really comprise the whole field of surgery from the viewpoint of the foremost British practitioners. Volume I will be ready about the middle of April, and the remaining two volumes will be published about autumn, 1912. The price of the work will be $21.00 per set.

Surgical Clinics of John B. Murphy, M.D.—Volume I, Number 1. The surgical clinics of John B. Murphy, M.D., at Mercy Hospital, Chicago. Volume I, Number 1. Octavo of 133 pages, illustrated. Philadelphia and London: W. B. Saunders Compasy, 1912. Published bi-monthly. Price per year: Paper, $8.00; cloth, $12.00. W. B. Saunders Company, Philadelphia, London.

These are not students' clinics, but Dr. Murphy's famous clinical talks at Mercy Hospital, Chicago, for physicians only. A point we want to mention is that these "Clinics" are published just as delivered by Dr. Murphy, being reported verbatim by an expert medical stenographer. In this way they retain all that individual force and charm so characteristic of the clinical teaching of this distinguished surgeon. We acknowledge with thanks to the well-known publishers the receipt of the first number of this valuable publication. To those who cannot in person attend the clinics of this distinguished surgeon, the leading exponent of the art of surgery in the United States, this publication will place before them a clear exposition of the author's views and methods as to surgical operations. Next to sitting

under the teaching of this surgeon, this work enables the reader to become acquainted with practical clinical teachings as adopted by this great surgeon. These clinics are issued in serial form, one number every other month.

SURGICAL OPERATIONS.—A handbook for students and practitioners, by Prof. Frederick Pils-Leusden, Chief Surgeon to the University Surgical Clinic and Chief of the University Surgical Polyclinic is the Royal Charity Hospital of Berlin. Only authorized English translation by Faxton E. Gardner, M.D., New York, with six hundred and sixty-eight illustrations. New York: Rebman Company, 1123 Broadway.

This is a most excellent hand-book for the use of students and general practitioners. What commends itself most particularly to the reader is the excellent character of the numerous diagrams and illustrations, as well as the clearness and succinctness of the text. We have taken the greatest interest in the examination of this book, and we can conscientiously recommend it as a trustworthy guide to beginners in surgical work, and it will prove of interest and help to the specialists in this branch of medicine. We are glad to see that the author urges persistent work upon the cadaver and the dog as preliminary training in the performance of surgical operations. There are entirely too many surgeons nowadays who are totally devoid of long training in surgical methods.

PROGRESSIVE MEDICINE.—A Quarterly Digest of Advances, Discoveries and Improvements in the Medical and Surgical Sciences. Edited by Hobart Amory Harey, M.D., Professor of Therapeutics and Materia Medica in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; one time Clinical Professor of Diseases of Children in the University of Pennsylvania; member of the Association of American Physicians, etc. Assisted by Leighton F. Appleman, M.D., Instructor in Therapeutics, Jefferson Medical College, Philadelphia; Ophthalmologist to the Frederick Douglas Memorial Hospital; Instructor in Ophthalmology, Philadelphia Polyclinic Hospital and College for Graduates in Medicine. Volume I, March, 1912. Surgery of the Head, Neck and Thorax; Infectious Diseases, Including Acute Rheumatism, Croupous Pneumonia, and Influenza;

Diseases of Children; Rhinology and Laryngology; Otology. Lea & Febiger, Philadelphia and New York, 1912.

We acknowledge with thanks the receipt of the March number of this valuable quarterly publication. As we have remarked in connection with our reviews of preceding numbers of this publication, there is none other that so completely carries out the object of the editors—that is, to present in readily accessible form the cream and essence of all recent advances and discoveries in the ralms of medicine. To the practitioner who desires to be *en rapport* with advanced medicine this quarterly is invaluable. The editors are well-known and able, and the corps of contributors selected for their ability and fitness for handling the subjects to which they have been assigned. The contents of this number are as follows: "Surgery of the Head, Neck and Thorax," by Charles H. Frazier, M.D.; "Infectious Diseases, Including Acute Rheumatism, Croupous Pneumonia, and Influenza," by John Rubrale, M.D.; "Diseases of Children," by Floyd M. Crandall, M.D.; "Rhinology and Laryngology," by D. Braden Kyle, M.D.; "Olotogy," by Arthur B. Duel, M.D.; Index. We cannot too strongly urge upon the profession the importance of this serial, and think that every up-to-date physician should become a subscriber.

The Friends of the Insane.—The Soul of Medical Education and other essays, by Bayard Holmes, M.D., Chicago, Ill. Price, $1.00. Cincinnati: The Lancet-Clinic Publishing Co., 1911.

This writer's strong little volume is made up from contributions on various subjects to the *Lancet Clinic*. It represents a collection of many entertaniing essays on various subjects. Of these the first, treating of the management of the insane, is the most important. It is a plea for more attention being paid to efforts at curing the insane. These unfortunates are cared for by the State and at private sanitaria, not for their own good but for the good and safety of the sane. The suggestions of the author for the better care of the insane are reasonable and practicable. This first essay is exceedingly valuable and is followed by quite a number of other essays on different topics that furnish

good reading for the profession. Lack of space prevents more extended notice of these essays, but we may say in conclusion that the little volume is well worth reading from beginning to end.

TEXTBOOK OF OPHTHALMOLOGY.—In the form of clinical lectures, by Dr. Paul Roemer, Professor of Ophthalmology at Griefswald. Volume I, cloth, $2.50. Translated by Dr. Matthias Lanckton Foster, member of the American Academy of Ophthalmology and Oto-Laryngology, with one hundred and eighty-six illustrations in the text and thirteen colored plates. Volume I. New York: Rebman Company, 1123 Broadway.

This excellent work is the outcome of a series of lectures delivered by the author at Griefswald, and has been published in response to the petition of his students who desired to keep in permanent form the instruction as given them by their teacher in his lectures. That the work will prove of value to the profession at large is manifest, as it contains the distinguished author's lectures pretty much as delivered by him, profusely illustrated and systematically arranged. We should consider the book of the greatest value to the specialist and to the teacher of this specialty.

Publisher's Department

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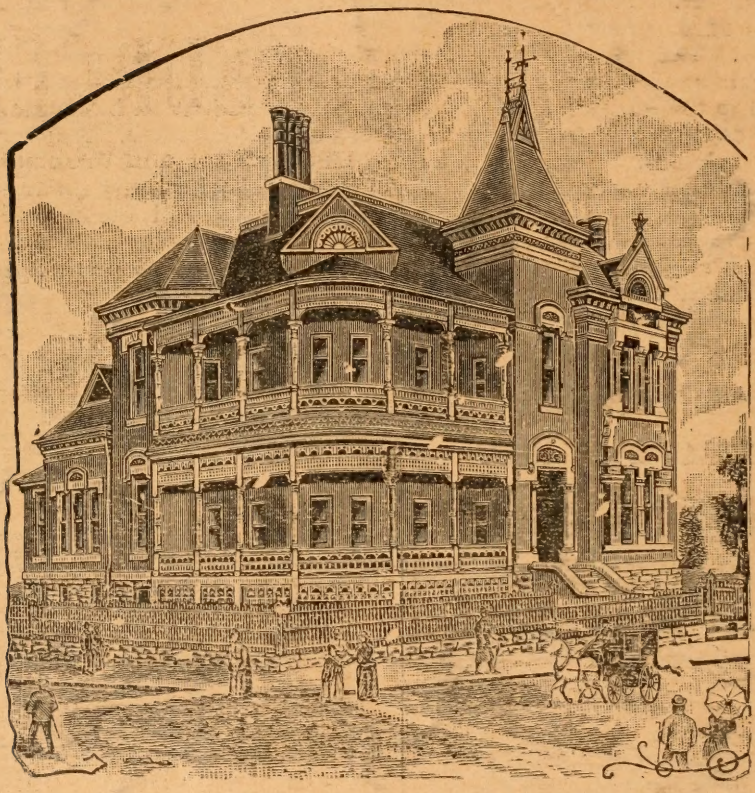

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